U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 23 May 2005

CASE No.: 2004-BLA-00065

In the Matter of:

CLYDE GRAMES,
Claimant

v.

U.S. FUEL COMPANY,
Employer

And

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

Appearances:

Jonathan Wilderman, Esquire
For Claimant

Bruce Wycoff, Esquire
For Employer

BEFORE: RUSSELL D. PULVER
Administrative Law Judge

DECISION AND ORDER- DENYING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901 et seq. (the Act). Regulations implementing the Act have been published by the Secretary of Labor in Title 20 of the Code of Federal Regulations. [1]

[1] The Secretary of Labor adopted amendments to the "Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969" as set forth in Federal Register/Vol. 65, No. 245 Wednesday, December 20, 2000. The amended Part 718 regulations became effective on January 19, 2001 and were to apply to both pending and newly filed cases. The new Part 725 regulations also became effective on January 19, 2001. Some of the new procedural aspects of the Part 725 regulations, however, were to apply only to claims filed on or after January 19,

The Act provides benefits to persons totally disabled due to pneumoconiosis and to certain survivors of persons who had pneumoconiosis and were totally disabled at the time of their death or whose death was caused by pneumoconiosis. Pneumoconiosis is a chronic dust disease of the lungs, including respiratory and pulmonary impairments arising out of coal mine employment, and is commonly referred to as black lung.

The Director, Office of Workers' Compensation Programs, referred this case to the Office of Administrative Law Judges on September 3, 2003 for a formal hearing.[2] DX 27. A hearing was held before me on October 27, 2004 in Price, Utah (see "Background and Procedural History", infra, for a complete account of the procedural history of this case).[3]

The findings of fact and conclusions of law that follow are based upon my analysis of the entire record, including all documentary evidence admitted, arguments made, and the testimony presented. Where pertinent, I have made credibility determinations concerning the evidence.

2001, *not* to pending cases. The Amendments to the Part 718 and 725 regulations were challenged in a lawsuit filed in the United States District Court for the District of Columbia in *National Mining Association v. Chao*, No. 1:00CV03086 (EGS). On February 9, 2001, the District Court issued a Preliminary Injunction Order that enjoined the application of the Amendments "except where the adjudicator, after briefing by the parties to the pending claim, determines that the regulations at issue in the instant lawsuit will not effect the outcome of the case." On August 9, 2001, the United States District Court for the District of Columbia issued a decision granting the U.S. Department of Labor's motion for summary judgment in *National Mining Association v. Chao*, dissolved the preliminary injunction, and upheld the validity of the amended regulations. The case was subsequently appealed and on June 14, 2002, the United States Court of Appeals for the District of Columbia Circuit issued a decision that affirmed in part, reversed in part and remanded the case back to the District Court for further instruction. The Court of Appeals upheld the validity, for the most part, of the challenged amendments except that the Court found the following sections to be impermissibly retroactive: §§718.204(a), 725.701, 725.101(a)(31), 725.204, 725.212(b), 725.213(c), 725.214(d), 725.219(c) and (d). The Court also found §725.101(a)(6) to be invalid.

[2] The following references will be used herein: TR for transcript, CX for Claimant's exhibit, DX for Director's exhibit, and EX for Employer's exhibit.

[3] At the hearing, Director's exhibits 1 through 36 (TR 7-8), Claimant's exhibits 1 through 10 and 12 through 18 (TR 8-10, 121, 133-134), Employer's exhibits 1 and 2 (TR 10-11), and ALJ exhibits 1 through 5 (TR 6) were admitted into evidence without objection. The record was left open for the rebuttal reports of Drs. Pearl and Farney. TR 16. Post-hearing, Claimant submitted the 11-10-04 report of Dr. Pearl. Said exhibit is marked Claimant's exhibit 19 and is admitted into the record. Claimant also submitted the B-reader certification of Dr. Leslie Preger. Said exhibit is marked Claimant's exhibit 20 and is admitted into evidence. Post-hearing, Employer submitted exhibits 3 (the medical records from Dr. Pearl), 4 (files of Dr. Potter) and 5 (files of Dr. Heiner) and the 11-14-04 supplemental medical report of Dr. Farney. The last exhibit is hereby marked Employer's exhibit 6. Employer also submitted the 12-2-04 supplemental medical report of Dr. Farney which is hereby marked Employer's exhibit 7. Employer's exhibits 3 though 7 are admitted into evidence.

ISSUES

The following issues remain contested:

(1) Whether Claimant has pneumoconiosis as defined by the Act and regulations;
(2) Whether his pneumoconiosis arose out of coal mine employment;
(3) Whether Claimant has a totally disabling respiratory impairment; and
(4) Whether his total disability is due to pneumoconiosis. DX 34; ALJ exhibit 5.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Background and Procedural History[4]

Claimant, Clyde Grames filed his claim for benefits on April 29, 1999. DX 1. On October 14, 1999, the claims examiner denied Claimant's claim for benefits. The claims examiner found Claimant failed to establish any/all elements of entitlement. DX 24. Claimant disagreed with the determination and requested a formal hearing. DX 27. An informal conference was held on February 27, 2001 and on June 10, 2003 a Memorandum of Conference and Stipulation of Uncontested Issues was issued by the District Director. The parties agreed that Claimant had at least 26 years of coal mine employment and that U.S. Fuel was the properly designated responsible operator. After a review of the medical evidence the District Director concluded that the miner did not have coal worker's pneumoconiosis ("CWP"), nor was he totally disabled due to CWP. DX 31. Claimant disagreed with the determination and requested a formal hearing. DX 33.

At the hearing, Claimant testified that he was born on September 16, 1928 and was 76 years old. His wife's name was Betty and they have been married since May 17, 1948. TR 32. He testified that his last coal mine employment was with U.S. Fuel Company. TR 32-33. His last position was as a face boss set up foreman. Claimant's last day of work in the coal mine was on March 31, 1988. TR 33. Claimant's responsibilities included keeping the ventilation up to standard, inspect machinery in the mine, direct the work force regarding the maintenance of machinery, roofing bolting, and general clean up. TR 33-34. He noted that he was exposed to large quantities of coal dust in the return air areas of the mine that he was required to inspect. TR 35. He testified that he was exposed to coal mine dust throughout his career as a coal miner. TR 36-42. Claimant stated that in his last position he was in charge of an area about 1000 feet long from the face to the feeder breaker. He had to check all of the faces every two hours as required by law. TR 42. In doing this job, Claimant was constantly walking. In addition, three out of five days per week, Claimant was involved in shoveling coal into the feeder breaker. TR 43-44. In repairing mining equipment, Claimant had to lift heavy machinery parts. TR 44. He

[4] Given the filing date of this claim, subsequent to the effective date of the permanent criteria of Part 718, (i.e. March 31, 1980), the regulations set forth at 20 C.F.R. Part 718 will govern its adjudication. Because Claimant's last exposure to coal mine dust occurred in Utah this claim arises within the territorial jurisdiction of the United States Court of Appeals for the Tenth Circuit. *See Broyles v. Director, OWCP*, 143 F.3d 1348, 21 BLR 2-369 (10th Cir. 1998).

added that many of the parts weighed over 100 pounds. TR 45. He also had to lift bags of rock dust and resin used to cement the roof bolts in place. These boxes weighed close to 100 pounds. TR 46. After leaving the mines in 1988, Claimant was a mail carrier for the U.S. Post Office from 1988 to 1990. TR 48. In 1990, Claimant retired because he could not do the job anymore. TR 48. He then worked for a home improvement store for about one year. TR 50. Claimant has not worked since that time. TR 50.

Claimant stated that he continued to have a dry cough as reported to Dr. Poitras in 1999. TR 50. He noticed that he coughs when doing lifting or walking. TR 51. He stated that he became short of breath and that his legs would become weak. TR 51. He added that his condition had gotten worse since 1999. TR 51. Claimant testified that he no longer does much heavy work around the house. TR 52. Claimant opined that he would not be able to perform his last coal mine position due to his shortness of breath. TR 53.

Claimant stated that he smoked one pack of cigarettes per day from 1945 to 1957 and then again from 1962 to 1971. TR 53. Claimant has not smoked at all since 1971. TR 54. Dr. Pearl has been his treating pulmonologist since January of 1985. TR 55. Claimant did not see Dr. Pearl from 1985 to 1993. He then started having difficulties breathing and went back to see Dr. Pearl. TR 56. He has been treating with Dr. Pearl regularly since then. TR 56. Claimant was not aware of any beryllium exposure. TR 57-58.

On cross-examination, Claimant denied smoking for 33 years as noted by Dr. Pearl in a report dated February 18, 1999. TR 63-64. Claimant reviewed his employment history noting that at different times he worked as a welder, a mechanic's helper, jack hammer operator, sewer service man, service station manager, installation man for propane heaters and furnaces, electrician, and mail carrier. TR 65-76. Since 1999 Claimant has had operations on his hands, feet, and shoulders. TR 76. Claimant stated that he used a grinding wheel to sharpen mower blades, knives, and chisels. TR 77.

Dr. Farney testified as a witness at the hearing. A summary of his testimony will appear infra in the medical report section of this opinion.

Medical Evidence

Chest X-rays

EX 4	12-5-85	Potter/Castleview Hospital	Some chronic obstructive pulmonary disease, findings suggestive of emphysematous bullae
EX 4	1-22-93	Shey/Castleview	COPD, interval

		Hospital	resolution of right sided pleural effusion
DX 18	9-29-94	Mann/BCR,B LDS Hospital	Many small nodular opacities, largest 3 to 4 mm, findings consistent w/pleural thickening, atelectasis or parenchymal scarring
DX 18	4-20-95	Hardy/LDS Hospital	Many tiny nodular opacities in upper 2/3 of both lung fields, measuring up to 3 to 4 mm, no significant change from 1994
DX 18	10-10-96	Mann/BCR,B LDS Hospital	Nodular opacities unchanged in profusion, differential diagnosis includes parenchymal granulomatous disease, minimal pleural thickening unchanged, segmental opacities consistent w/atelectasis or parenchymal scars unchanged
DX 18	9-25-97	Harker/LDS Hospital	Pulmonary nodules unchanged in size or appearance, no change in appearance of chest from 10-10-96
DX 18	6-18-98	Morrison/BCR,B LDS Hospital	No interval change from 1997
EX 4	2-4-99	Baldwin/Castleview Hospital	Bilateral mid and upper fibronodular densities, developed rheumatoid lung by history

CX 10	2-22-99	Morrison/BCR,B LDS Hospital	Multiple pulmonary nodules, upper lobes
CX 8	2-23-99	Francyk/LDS Hospital	Multiple pulmonary nodules
CX 9	2-23-99	Gabor/LDS Hospital	Multiple small, poorly marginated parenchymal nodules in left and right lungs
CX 7	3-11-99	Mann/BCR,B LDS Hospital	Bilateral nodular parenchymal opacities, unchanged in profusion
DX 16	5-24-99	Preger/ BCR,B	2/2, r/r, 6 zones, Cat. A (? protected over left clavicle)
DX 17	5-24-99	Sheya/ BCR	1/2, r/r, 3 zones, Cat.O
DX 21	7-28-99	Mann/BCR,B LDS Hospital	Increasing profusion of nodular opacities in upper lung zone, no evidence of coalescence of formation of large opacities, findings consistent w/granulomatous process such as sarcoidosis
EX 3	11-10-99	Mann/ BCR, B LDS Hospital	Parenchymal nodular opacities, upper lobes, unchanged, consistent w/sarcoidosis
EX 4	5-24-03	Sharma/Castleview Hospital	Bilateral nodules in both upper fields, chronic long-standing nodular lung disease secondary to rheumatoid arthritis by history
EX 1	9-27-04	Morrison/BCR,B	1/2, r/r, 3 zones, Cat. O,

			cardiomegaly, COPD and PAH, pleural fibrosis probably not related to CWP since no evidence of pleural plaques
EX 1	9-27-04	Black/Castleview Hospital	Nodular infiltrates both upper lungs, similar to 6-17-04, may represent silicosis or CWP but non-specific in appearance, probable fibrosis in both lower lungs

CT Scans

DX 18	9-29-94	Davis/LDS Hospital	Small periphery nodules measuring 1 to 5 mm, differential concerns for small nodule pattern include sarcoidosis, silicosis, CWP, extrinsic allergic alveolitis or histiocytosis, and atypical presentation of malignancy
DX 18;CX 6	2-18-99	Pisani/LDS Hospital	Numerous small parenchymal nodules w/2 calcified hilar and subcarinal lymphadenopathy, most likely represents inorganic dust exposure such as

			silicosis or CWP, sarcoidosis remains in the differential
CX 16	6-22-04	Hammond/Castleview Hospital	Largest pulmonary nodule is 8.4 mm, largest pleural based nodule is 1.2 cm in size, large pulmonary emboli, multiple nodules bilaterally suspicious for metastatic malignancy
EX 1	9-1-04	Morrison/BCR,B LDS Hospital	Chronic bilateral pulmonary nodules, most likely represent chronic pneumoconiosis, class r, greater than 3 mm, mild centrilobular emphysema, chronic mild bilateral hilar adenopathy

Medical Reports: Radiologists

Dr. Howard Mann

The medical report of Dr. Mann is dated September 15, 1999 and appears at DX 21. Dr. Mann prepared a summary of chest radiographic findings on Claimant. He reviewed chest x-rays from 4-95, 9-97, 6-98, 3-99, and 7-99. He found that the x-rays showed an increasing profusion of nodular opacities in the upper lung zones. He added that there was no evidence of coalescence or the formation of large opacities or localized emphysema. He opined that the findings were consistent with a granulomatous process such as sarcoidosis but not consistent with inorganic dust pneumoconiosis.

Pulmonary Function Studies[5]

DX 18	8-26-94	65	169 cm (66.5")	2.79	----	4.21	No
DX 15	4-14-99	70	169 cm (66.5")	2.39 *2.57	----	3.80 *3.77	No No
DX 15	5-23-99	70	68"	1.94	----	2.68	No
DX 22	8-27-99	70	66"	2.43 *2.61	----	3.97 *4.04	No No
EX 3	11-10-99	71	169 cm (66.5")	2.32	----	3.80	No
EX 3	4-26-00	71	169 cm (66.5")	2.59	----	3.96	No
EX 1	9-1-04	75	167cm (65.8")	2.46 *2.74	103 ----	4.11 *4.15	No No
EX 1	9-1-04	75	65"	*2.10	----	*3.28	No

*post-bronchodilator

Arterial Blood Gas Studies

DX 14	5-25-99	79.2 *67.3	35.5 *32.1	No Yes
EX 1	9-1-04	74 *80	35.7 *28.8	No No

*post-exercise

Medical Reports: Pathologists

Open Right Lung Biopsy: Dr. Michael P. Collins

The operative report of Dr. Collins is dated February 19, 1999 and appears at DX 18. Dr. Collins summarized his findings and stated that the right lower lobe and some of the upper lobe were involved in a pleural scarring process which in areas coalesced into one big visceral pleural mass. He added that this had the physical appearance of silicosis. Dr. Collins noted that frozen sections showed no malignant process but merely fibrosis and "probable silicosis."

A narrative report by Dr. Collins is dated February 24, 1999 and appears at CX 15. Dr. Collins indicated that the final pathologic diagnosis after thorough scrutiny of the submitted specimen from surgery showed remote hyalinized granulomas in which there were well-formed small collections of granulomas with occasional small minimally refractile particles. Diagnosis

[5] Due to the discrepancy in height, qualification of the vent studies is based on an average height of 66.35 inches.

at the time of discharge was bilateral pulmonary nodules, granulomas by pathologic diagnosis, and COPD secondary to above.

Dr. Ronald M. Harris

The pathology report of Dr. Harris is dated February 22, 1999 and appears at CX 5. The pre-operative diagnosis was bilateral pulmonary nodules and the final diagnosis was remote hyalinized granulomas. Microscopic examination showed largely hyalinized and amorphouseosinophilic material surrounded by foci of granulomatous and chronic inflammation. There were well-formed small collections of granulomas with occasional small, minimally refractile particles. Findings were suggestive of a remote granulomatous process.

Dr. Thomas Colby

The medical report of Dr. Colby is dated September 21, 1999 and appears at DX 19. Dr. Colby is a highly distinguished pathologist for the Mayo Clinic Scottsdale and has many publications in peer review journals regarding the pathology of pulmonary diseases. DX 20. Dr. Colby reviewed a lung biopsy of Claimant and noted that the hyalinized nodules were those seen in infection (such as histoplasmosis and others), sarcoidosis, and berylliosis. He noted that the center of the nodules raised the possibility of silicotic nodules but that there was relatively little dust around and that silica did not produce a granulomatous reaction that was present here. Dr. Colby stated that a histo[plasmosis] infection could appear this way or that some mycobacterial infections could present in a similar way. He suggested exploring with Claimant a history of possible exposure to beryllium. Dr. Colby's diagnosis was open lung biopsy showing hyalinizing nodules with granulomatous inflammation, granulomatous disease was favored.

A second medical report of Dr. Colby is dated September 27, 1999 and appears at DX 20. He indicated that he reviewed the biopsy slides from February of 1999. He explained that he initially thought this was a pathologist-to-pathologist consultation, which was the reason for the first report. He prepared this report in response to a letter from Employer's attorneys. He stated there was a small amount of anthracotic pigment present, consistent with Claimant's smoking history. He added there was nothing that would suggest an increased load of anthracosis (such as from coal mining) based on the histology. He stated there was no significant reaction of the lung at the histologic level to carbon or silica deposition. Dr. Colby noted that polarization showed relatively little polarizable material for an adult with a history of smoking and nothing like the amount of material one sees in a case of severe anthracosis, silicosis, or anthracosilicosis. He opined that the main pathologic process was a granulomatous condition, either sarcoidosis or berylliosis, or less likely, a peculiar granulomatous infection. Dr. Colby concluded Claimant did not have CWP, silicosis, or anthracosilicosis. He added that there were significant pathologic changes present in the biopsy in the form of nodules which may or may not cause significant functional impairment and that impairment and disability was better addressed with clinical evaluation and pulmonary function studies rather than histologic interpretation.

Dr. J. Wallace Graham

The medical report of Dr. Graham is dated September 30, 2004 and appears at CX 1. Dr. Graham's credentials are not part of the record. Dr. Graham reviewed the lung biopsy slides and described the lung as having multiple granulomas. He diagnosed Claimant as having nonspecific granulomatous inflammation, lung, with emphysematous changes and pulmonary arteriolosclerosis.

Medical Reports: Internal Medicine

Dr. Jean-Maurice Poitras

The medical report of Dr. Poitras is dated May 24, 1999 and appears at DX 13. Dr. Poitras is Board-Certified in Internal Medicine. CX 2. Dr. Poitras examined Claimant at the request of the Department of Labor. Dr. Poitras reviewed Claimant's employment history and noted a family history of heart disease. Claimant reported a medical history of heart disease and that he had been seeing a pulmonologist for the last fifteen years for pulmonary nodules. Dr. Poitras noted a smoking history of one pack of cigarettes per day from 1945 to 1971. Claimant's chief complaints included dyspnea, cough chest pain, and orthopnea. Physical examination revealed slightly decreased lung sounds on auscultation. Clubbing was noted in the upper and lower extremities. A chest x-ray showed ill-defined densities, a vent study showed a mild restriction, arterial blood gases were normal, and an EKG was borderline normal. Dr. Poitras diagnosed Claimant as having mild to moderate restrictive lung disease, lung nodules, and cough. He stated that this process was not wholly inconsistent with tobacco smoking and that it was consistent with a fibrotic process such as pneumoconiosis found in coal workers. He concluded Claimant had a mild to moderate impairment and that he was limited in his physical activities. Dr. Poitras opined that "certainly" Claimant's 20 years of smoking played a role in his impairment and ventured 60% due to coal exposure and 40% due to tobacco.

Dr. Robert J. Farney

The medical report of Dr. Farney is dated August 27, 1999 and appears at DX 22. Dr. Farney examined Claimant on August 27, 1999. Dr. Farney obtained a detailed occupational and medical history and performed a physical examination. In addition he ordered pulmonary function studies and reviewed serial chest films and CT scans that had been interpreted by Dr. Mann (a radiologist and B-reader). He noted that Claimant had a lung biopsy on February 19, 1999 and that he had examined the pathology slides with Dr. Flinner (a pulmonary pathologist). Dr. Farney also examined medical records from Drs. Potter, Pearl, and Knibbe.

Claimant's chief complaints were progressive shortness of breath since 1985 and persistent dry cough. Dr. Farney noted a smoking history of 21 pack years starting at age 17 to 1957 then from 1962 until 1971. Claimant stopped smoking in March of 1971. Dr. Farney reviewed Claimant's lengthy employment history and noted that his last coal mine employment was as a face boss. Claimant was required to walk extensively as part of his job checking for explosive gas and ventilation of the mine. Dr. Farney summarized Claimant's medical history and noted that pulmonary nodules were first identified on September 29, 1994. Physical

examination was unremarkable. An EKG showed normal sinus rhythm with PVC's. Pulmonary function studies showed mild pulmonary obstruction and chest radiographs showed nodular opacities without evidence of coalescence and were most consistent with a granulomatous process such as sarcoidosis but not pneumoconiosis. Review of the lung biopsy showed the presence of noncaseating granulomata. It was noted that the typical histiopathologic features of CWP were not present. The granulomatous reaction tended to be pleural based and most consistent with sarcoidosis. Dr. Farney concluded Claimant had a granulomatous pulmonary disease of uncertain etiology. He noted that the radiographic pattern, distribution, and histopathology were most consistent with sarcoidosis. He added that beryllium exposure could result in a similar reaction but that there was no historical evidence of exposure to beryllium. Dr. Farney stated that the pulmonary function measurements were stable and did not indicate the presence of disability. He noted that the mild obstruction and reduction of diffusing capacity were consistent with mild emphysema. Dr. Farney concluded that the granulomatous disease would not be expected to cause pulmonary impairment because of the limited extent and distribution localized to the upper lung zones. He opined the evidence of record did not support a finding of pneumoconiosis and that there was no evidence of physiologic deterioration that would indicate a disabling respiratory impairment.

The second medical report of Dr. Farney is dated October 7, 2004 and appears at EX 1. Dr. Farney is Board-Certified in Internal Medicine and Pulmonary Disease. EX 2. Dr. Farney examined Claimant for a second time on September 1, 2004. Claimant complained of increasing shortness of breath and persistent cough. Physical examination was unremarkable. Pulmonary function testing showed normal lung volumes with mild to moderate airflow obstruction with positive bronchodilator response and low normal diffusion capacity. Dr. Farney reviewed the interpretation of Dr. Morrison (radiologist and B-reader) of the 9-27-04 chest x-ray and 9-21-04 CT scan. He also reviewed the films and agreed that they showed 1/2, r opacities in the upper lungs zones. Mild central lobular emphysema was also present in the upper lobes. Dr. Farney concluded that from his previous examination, there had been no significant change in Claimant's pulmonary function or status of evidence of interstitial lung disease. The chest x-rays and CT scans showed no progression and the vent measurements were stable. He added that the basis for Claimant's limitation on exercise on spirometry was multifactoral and included deconditioning, airways obstruction, and possibly pulmonary vascular disease. Dr. Farney opined there was no evidence of progressive interstitial disease or evidence of CWP.

Dr. Farney testified at Claimant's hearing on October 27, 2004. Dr. Farney opined that Claimant did not have pneumoconiosis. He noted Claimant's chest x-rays showed pulmonary nodules but that the nodules on biopsy displayed non-pneumoconiosis pathology. He diagnosed Claimant with granulomatous disease, some obstructive lung disease, and pulmonary embolism. He noted that cellular features were different in a coal worker's nodule as opposed to a granulomatous nodule and that a pathologist made this type of distinction. Dr. Farney opined that Claimant's respiratory condition would not prevent him from performing his last coal mine work. He noted that Claimant's acute onset of nodules followed by a long period of stability would not be consistent with pneumoconiosis. Dr. Farney disagreed with Dr. Pearl's statement that the biopsy showed evidence of pneumoconiosis. Dr. Farney indicated that four pathologists examined the slides and none made a diagnosis of pneumoconiosis.

On cross-examination, Dr. Farney noted there was some coalescence of nodules from 1994 to 1999 on the CT scans but that part of the difference was due to technical differences in the scanning equipment. Dr. Farney agreed that Dr. Morrison (a B-reader) found evidence of COPD on the most recent chest x-ray. He agreed that Claimant had COPD. Dr. Farney agreed that surgeons in February of 1999 only biopsied the right side of Claimant's lung. Dr. Farney acknowledged that coal mine dust exposure can cause obstructive lung disease. He noted that increasing dust exposure and accumulation had a greater effect on lung function in those people with greater sensitivity. He also agreed that coal mine dust inhalation could be disabling. Dr. Farney agreed that both legal pneumoconiosis and clinical pneumoconiosis could progress after cessation of exposure. Dr. Farney indicated that it would be highly unusual for a patient to develop radiographic evidence of CWP seven years after cessation of coal mine employment. He questioned the validity of the arterial blood gas results from 1999 and opined that even if the values were valid they did not necessarily indicate the presence of a respiratory impairment.

On redirect, Dr. Farney stated that he relied on the pathology as the gold standard in making his diagnosis. He noted that there was nothing in Dr. Morrison's x-ray interpretation that was inconsistent with a diagnosis of granulomatous disease or sarcoidosis. He agreed that a 20 pack year smoking history could cause COPD. Dr. Farney added that the sudden appearance of multiple small nodules in 1992 was not consistent with CWP which progressed very slowly. However, such a sudden manifestation of pulmonary nodularity was consistent with sarcoidosis.

The third medical report of Dr. Farney is dated November 14, 2004 and appears at EX 6. Dr. Farney reviewed the August 25, 2005 letter of Dr. Pearl. He disagreed with Dr. Pearl's assertion that Claimant had radiographic and biopsy proof of CWP. Dr. Farney noted that according to the four or five pathology reports he reviewed, the histologic findings were not consistent with pneumoconiosis. None of the pathologists made a histologic diagnosis of pneumoconiosis. Dr. Farney also reviewed the radiographic report of Dr. Hammond of the CT scan from June 22, 2004. He noted that the observations were not specific and were consistent with multiple nodular pulmonary diseases including sarcoidosis and other granulomatous diseases. He added that although the radiographic images could be consistent with pneumoconiosis, the findings were somewhat unusual for CWP because of the heterogenous and pleural-based pattern. He also commented on studies regarding the association of coal dust, cigarette smoking, and COPD.

The fourth medical report of Dr. Farney is dated December 2, 2004 and appears at EX 7. Dr. Farney reviewed additional correspondence from Drs. Knibbe and Pearl. He noted that these documents substantiated his earlier testimony that the nodular lung disease was most likely a delayed consequence of an acute inflammatory or infectious process. He added that the precise etiology of the acute illness could not be determined but the ultimate development of pulmonary nodules was most likely due to this acute inflammatory process. He noted that coal dust exposure could not have caused the acute pleural disease or subsequent nodular disease that was eventually shown by open biopsy to be "non-specific granulomatous" a description that was often associated with fungal infections, tuberculosis, etc.

Dr. James E. Pearl

The medical report of Dr. Pearl is dated August 25, 2005[sic] and appears at CX 12. Dr. Pearl is Board-Certified in Internal Medicine. CX 13. He noted that he had treated Claimant since 1985 and at that time he had had chest x-ray abnormalities consistent with CWP. Claimant later had a change in these pulmonary nodules that required biopsy. Dr. Pearl stated, "He was found at that time to have extensive coal worker's pneumoconiosis by biopsy." He added that the nodules have remained stable. Dr. Pearl stated, "He has both radiographic and biopsy proof of coal worker's pneumoconiosis and there should be no question about this. The histologic diagnosis was unmistakable and it did not represent any other pathological state." Dr. Pearl opined that Claimant's underlying lung disease contributed to his disability but that there was no recent pulmonary function test to quantitate the disability.

The supplemental report of Dr. Pearl is dated November 10, 2004 and appears at CX 19. Dr. Pearl stated that he reviewed additional unspecified information regarding this case and that he had reviewed a recent CT scan. He concluded that after reviewing this data, Claimant did not have coal worker's pneumoconiosis. He noted that Claimant did have significant exposure to silica dust. He added that the refractile material seen in the biopsy was not as extensive as was typically seen in heavy silica exposure. Dr. Pearl stated that the CT scan showed evidence of emphysema. He noted that Claimant was a non-smoker and opined that Claimant's dust exposure "may at least be in part responsible for this parenchymal destructive process." In the next paragraph of his report, Dr. Pearl noted Claimant had a smoking history of 33 years ending in 1971 and that he had heavy exposure to silica dust. He noted that Dr. Collins initially thought Claimant had silicosis but that the lack of high volume of mineral material in the lungs put that diagnosis in question. Dr. Pearl stated that Claimant had significant lung disease with moderate obstruction. He added that Claimant had no other etiology and had parenchymal lung destruction "which may relate to dust and diesel fume exposure" from his work in the mines. Dr. Pearl added, "It is my supposition that Mr. Grames suffers from lung disease of a mixed nature including emphysema and granulomatous lung disease which may be in part secondary to silica which contributes to his lung problem. I have no other explanation other than his exposure to dusts and diesel fumes in the mine. It is my opinion with a moderate degree of medical certainty that Mr. Grames has his lung disease based on his exposure to diesel fumes and silica dust which he received while in the employ of the mine company."

Miscellaneous Medical Records

Dr. James E. Pearl

The medical records of Dr. Pearl appear at DX 18. The earliest medical letter from Dr. Pearl is dated January 17, 1985 when Dr. Pearl diagnosed Claimant as having a mixed collagen vascular disease. He noted that Dr. Knibbe, a rheumatologist, was called in for a consultation. In a note dated November 11, 1985, Dr. Pearl indicated that he reviewed a chest x-ray with a radiographer and determined that there was no evidence of a nodule or tumor and advised Claimant to continue his work in the coal mines.

After a period of eight years, Claimant returned to see Dr. Pearl on April 21, 1993 for evaluation of persistent cough. Physical examination was unremarkable and spirometry showed a mild obstruction. Dr. Pearl diagnosed Claimant as having reactive airways disease and started him on an inhaler. Dr. Pearl noted that the chest x-ray from January showed no evidence of acute disease. Claimant returned on May 20, 1993 feeling significantly better and was advised to continue with the inhaler. Claimant had a similar examination on September 30, 1993.

On August 25, 1994, Claimant returned feeling worse. It was noted that a recent x-ray (August 17, 1994) showed multiple irregular pulmonary nodules. Claimant returned on September 29, 1994 feeling fairly well with no cough or sputum production. The chest x-ray, according to Dr. Pearl's reading, revealed an increase in size of the pulmonary nodules with slight coalescence. Dr. Pearls scheduled a CT scan for further evaluation. Claimant saw Dr. Pearl again on December 8, 1994. Physical examination showed scattered crackles throughout both lung fields. The chest x-ray showed no significant change in the nodules.

Claimant returned on April 20, 1995. The chest x-ray remained unchanged. Claimant was evaluated again on September 21, 1995. Physical examination was unremarkable. The next visit with Dr. Pearl was on April 17, 1996. Claimant complained of trouble breathing when working in the garden. Physical examination was normal. Dr. Pearl noted that he was pleased Claimant was doing so well. Claimant returned on October 10, 1996 feeling relatively well. Physical examination of the lungs was clear. The chest x-ray showed the pulmonary nodules were stable.

Claimant was examined by Dr. Pearl on April 7, 1997. Claimant complained of exercise related chest pain with no other complaints. Claimant's dyspnea was noted to be about the same. Physical examination revealed clear lungs with diminished breath sounds. Claimant's lung therapy was continued. Claimant had a follow-up appointment with Dr. Pearl on September 25, 1997. Claimant was feeling relatively well with no complaints of chest pain, cough, or sputum production. Physical examination was normal. Claimant returned on March 11, 1998 with complaints of increasing shortness of breath. Lungs were clear with a slight increase in expiratory phase. Claimant's next appointment was on June 18, 1998. Claimant did not have any reported symptoms from his aortic insufficiency. Claimant's lungs were clear. The chest x-ray showed multiple pulmonary nodules with no significant change. Claimant returned on October 14, 1998 noting he was breathing without a great deal of difficulty. It was noted that Claimant did not have any real breathing complaints.

The next medical note was dated February 18, 1999. It was noted that the most recent CAT scan showed that Claimant's nodules had grown with new multiple nodules appearing. Dr. Pearl recommended a biopsy. Claimant returned on April 14, 1999. Dr. Pearl noted that Claimant returned feeling well with no cough, sputum production, or other complaints. He noted that Claimant was pleased that the biopsy showed CWP. Physical examination showed slightly diminished breath sounds with an increased expiratory phase.

The next medical note is dated March 28, 2001 and appears at EX 3. Claimant had been breathing without a great deal of difficulty. Claimant stated that he was told by a pathologist at the Mayo Clinic that he did not have CWP. The chest x-ray remained stable. The last office

note is dated October 6, 2004. Claimant complained of increasing breathing problems. Dr. Pearl reviewed documents and concluded Claimant had more of what looked like silicosis than pneumoconiosis. He added that it was most likely that the nodules represent silicosis on the basis of his coal mine work.

Dr. W. Patrick Knibbe

The medical notes of Dr. Knibbe appear at EX 4. Dr. Knibbe was a rheumatologist who treated Claimant in 1985 for treatment of possible rheumatoid lung disease.

Dr. Heiner

The medical notes of Dr. Heiner appear at EX 5. Dr. Heiner treated Claimant for multiple orthopedic complaints from 2001 through 2003.

Conclusions of Law

Length of Coal Mine Employment

The parties stipulated and I find that Claimant was a coal miner, within the meaning of the Act, for 26 years. DX 31.

Date of Filing

I find that Claimant filed his claim for benefits under the Act on April 29, 1999. DX 1.

Responsible Operator

The parties stipulated and I find the evidence of record supports the conclusion that U.S. Fuel Company is the properly named responsible operator in this case. DX 31.

Dependents

I find that Claimant has one dependent for purposes of augmentation of benefits under the Act, his wife, Betty. DX 1; DX 31.

Applicable Regulations

Claimant's claim for benefits was filed on April 29, 1999 and is governed by the Part 718 Regulations. However, on January 19, 2001, substantial changes to Parts 725 and 718 of the Federal Regulations became effective. (see footnote 1). Based upon my review of the new Regulations, there are two sections that specifically deal with the question of whether these new Regulations are applicable to cases that are currently pending at the time of the enactment.

Pursuant to § 725.2(c) the revisions of this part [Part 725] shall also apply to the adjudication of claims that were pending on January 19, 2001, except for the following sections: § 725.309, 725.310, etc. (see the C.F.R. for the complete list of exempted sections). Accordingly, with the exception of those sections listed as an exemption, the revisions to Part 725 will apply to the facts of this decision.

Pursuant to § 718.101(b) the standards for the administration of clinical tests and examinations contained in subpart B "shall apply to all evidence developed by any party after January 19, 2001 in connection with a claim governed by this part [718]..." (emphasis added). Accordingly, since some of the evidence in the instant matter was developed after January 19, 2001, the newly enacted § 718, subpart B will apply to said evidence.

On August 9, 2001, U.S. District Court Judge Emmet Sullivan upheld the validity of the new Regulations in *National Mining Association v. Chao*, No. 00-3086 (D.D.C. Aug. 9, 2001). However, on June 14, 2002, the United States Court of Appeals for the District of Columbia Circuit ("the court") affirmed in part, reversed in part, and remanded the case. *See National Mining Association v. Department of Labor,* No. 01-5278 (June 14, 2002). Accordingly, I will apply those sections of the newly revised version of Part 718 (i.e. subparts A, C and D) and Part 725 that took effect on January 19, 2001 that the court did not find impermissibly retroactive to the facts of the instant matter. (see footnote 1).

Entitlement: Determination of Pneumoconiosis

30 U.S.C. § 902(b) and 20 C.F.R. § 718.201 define pneumoconiosis as "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." [6] The definition is not confined to "coal workers' pneumoconiosis," but also includes other diseases arising out of coal mine employment, such as anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, progressive massive fibrosis, silicosis, or silicotuberculosis.[7] 20 C.F.R. § 718.201. The term "arising out of coal

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[6] Pneumoconiosis is a progressive and irreversible disease; once present, it does not go away. *Mullins Coal Co. v. Director, OWCP,* 484 U.S. 135, 151 (1987).

[7] Regulatory amendments, effective January 19, 2001, state:

(a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis.

(1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.

(2) Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or

mine employment" is defined as including "any chronic pulmonary disease resulting in respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment."

The claimant has the burden of proving the existence of pneumoconiosis by any one of four methods. The Regulations provide the means of establishing the existence of pneumoconiosis by: (1) a chest X-ray meeting the criteria set forth in 20 C.F.R. § 718.202(a); (2) a biopsy or autopsy conducted and reported in compliance with 20 C.F.R. § 718.106; (3) application of the irrefutable presumption for "complicated pneumoconiosis" found in 20 C.F.R. § 718.304; or (4) a determination of the existence of pneumoconiosis made by a physician exercising sound judgment, based upon certain clinical data and medical and work histories, and supported by a reasoned medical opinion. 20 C.F.R. § 718.202(a). Pulmonary function studies are not diagnostic of the presence or absence of pneumoconiosis. *Burke v. Director, OWCP*, 3 B.L.R. 1-410 (1981).

Chest X-ray Evidence

A finding of the existence of pneumoconiosis may be made with positive chest x-ray evidence. 20 C.F.R. § 718.202(a)(1). The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. A chest x-ray classified as category 0, including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 C.F.R. § 718.102(b). Where two or more x-ray reports are in conflict, the radiologic qualifications of the physicians interpreting the x-rays must be considered. §718.201(a)(1).

While a judge is not required to defer to the numerical superiority of x-ray evidence, although it is within his or her discretion to do so. *Wilt v. Woverine Mining Co.*, 14 B.L.R. 1-70 (1990) citing *Edmiston v. F & R Coal,* 14 B.L.R. 1-65 (1990). The ALJ must rely on the evidence which he deems to be most probative, even where it is contrary to the numerical majority. *Tokarcik v. Consolidation Coal Co.*, 6 B.L.R. 1-666 (1984).

In summary, there are nineteen (19) interpretations of seventeen (17) x-rays in the record. The Benefits Review Board has held that it is proper to credit the interpretation of a dually qualified physician over the interpretation of a B-reader. *Cranor v. Peabody Coal Co.*, 22 B.L.R. 1-1 (1999). (*en banc on recon.*). There are nine (9) interpretations by dually qualified Board-Certified Radiologists and B-readers (Drs. Morrison, Mann, and Preger) in this case. All nine

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impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure. (Emphasis added).

interpretations note the presence of pulmonary nodules but seven (7) interpretations do not mention a diagnosis of pneumoconiosis whereas two (2) interpretations were positive for pneumoconiosis based on an ILO classification. Moreover, Dr. Mann, one of the Board-Certified Radiologists and B-readers in this case, reviewed serial chest x-rays from 4-95, 9-97, 6-98, 3-99, and 7-99 and concluded that the findings were consistent with a granulomatous process such as sarcoidosis but was not consistent with inorganic dust pneumoconiosis. DX 21. Accordingly, as the majority of the more credible interpretations are negative for pneumoconiosis, I find that Claimant has failed to establish, by the preponderance of the evidence, the existence of pneumoconiosis pursuant to §718.202(a)(1).

Biopsy Evidence

Pursuant to §718.202(a)(2) Claimant may establish pneumoconiosis through the use of biopsy evidence. An open lung biopsy of the right lobes was conducted on February 19, 1999. DX 18. Dr. Collins, the surgeon, opined initially that his findings had the physical appearance of silicosis and that frozen sections showed no malignant process but merely fibrosis and "probable silicosis." However, in his narrative report, Dr. Collins noted that after thorough scrutiny of the specimen from surgery, his final diagnosis was changed to bilateral pulmonary nodules, granulomas by pathologic diagnosis and COPD secondary to above. Dr. Harris, a pathologist, reviewed the biopsy slides and noted that the findings were consistent with a remote granulomatous process. CX 5.

Dr. Colby, a highly distinguished pathologist, reviewed the surgical specimen and opined that the main pathologic process was a granulomatous condition, either sarcoidosis or berylliosis, or less likely, a peculiar granulomatous infection. Dr. Colby concluded Claimant did not have CWP, silicosis, or anthracosilicosis. DX 19, DX 20.

Dr. Graham also reviewed the lung biopsy slides and diagnosed Claimant as having nonspecific granulomatous inflammation with emphysematous changes and pulmonary arteriosclerosis. CX 1.

Based on the foregoing, at least three pathologists and one surgeon reviewed the biopsy slides and determined that Claimant had a granulomatous disease process and not coal worker's pneumoconiosis. There is no contrary biopsy evidence of record. Therefore, I find that Claimant failed to establish the existence of pneumoconiosis through biopsy evidence pursuant to §718.202(a)(2).

The Presumptions

Under §718.202(a)(3) it shall be presumed that a miner is suffering from pneumoconiosis if the presumptions provided in §§718.304, 718.305, or 718.306 apply.

Initially, I note that Claimant cannot qualify for the §718.305 presumption because he did not file this claim before January 1, 1982. Claimant is also ineligible for the §718.306 presumption because he is still living. Moreover Claimant is ineligible for the §718.304

presumption as there is no credible evidence that Claimant suffers from complicated pneumoconiosis.[8]

Based on the foregoing, it is clear Claimant has failed to establish the existence of pneumoconiosis pursuant to §718.202(a)(3).

Medical Opinions

Lastly, under §718.202(a)(4) a finding of pneumoconiosis may be based on the opinion of a physician, exercising sound medical judgment, who concludes that the miner suffers or suffered from pneumoconiosis. Such conclusion must be based on objective medical evidence and must be supported by a reasoned medical opinion.

Smoking History

In general, in order for physicians to arrive at a proper, reasoned diagnosis, it is essential that they be presented with an accurate picture of a patient's complaints, prior medical history, working or environmental conditions, and social habits, including smoking. See *Stark v. Director, OWCP*, 9 B.L.R. 1-36 (1986) (An opinion may be given less weight where the physician did not have a complete picture of the miner's condition.).

Specifically, in Black Lung cases, a claimant's smoking history is of particular importance. This is because the pulmonary manifestations of smoking are often similar to that of coal workers' pneumoconiosis.

At the hearing, Claimant testified that he smoked one pack of cigarettes per day from 1945 to 1957 then from 1962 to 1971. TR 53. There is no significant discrepancy in the record. Therefore, I find, based on the reported histories and Claimant's testimony, that Claimant had a 21 pack year smoking history ending in 1971.

Analysis of Medical Opinions

Of record are the opinions of (1) Dr. Poitras who found Claimant's mild to moderate restrictive lung disease and pulmonary nodules to be consistent with a fibrotic process such as pneumoconiosis, (2) Dr. Farney who found Claimant had a granulomatous pulmonary disease of uncertain etiology, and (3) Dr. Pearl who ultimately found Claimant suffered from lung disease

[8] Complicated pneumoconiosis is established by x-rays classified as Category A, B, C, or by an autopsy or biopsy that yields evidence of massive lesions in the lung. The 5-24-99 interpretation by Dr. Preger, a Board-Certified Radiologist and B-reader, classified the said chest x-ray as 2/2, r/r, 6 zones, Category A. No other radiologist made a diagnosis of complicated pneumoconiosis. In addition, the unequivocal biopsy findings noted the presence of a granulomatous disease process and no pneumoconiosis. Moreover, none of the physicians who rendered an opinion in this case diagnosed the presence of complicated pneumoconiosis. Accordingly, this presumption is not applicable.

of a mixed nature including emphysema and granulomatous lung disease which may be, in part, secondary to silica.

I first note that Drs. Poitras, Farney, and Pearl are highly qualified physicians who have excellent credentials. Dr. Farney is Board-Certified in Internal Medicine and Pulmonary Disease. Drs. Poitras and Pearl are Board-Certified in Internal Medicine. Accordingly, I find Drs. Poitras, Farney, and Pearl to be highly qualified to render an opinion in this matter. *Burns v. Director, OWCP*, 7 B.L.R. 1-597 (1984).

In addition, in weighing the medical evidence of record, the adjudication officer must give consideration to the relationship between the miner and any treating physician whose report is admitted into evidence. Factors to consider include the nature of the relationship, duration of the relationship, frequency of treatment, and extent of treatment. §718.104(d). In appropriate cases, the relationship between the miner and his treating physician may constitute substantial evidence in support of the adjudication officer's decision to give that physician's opinion controlling weight, provided that the weight given to the opinion of a miner's treating physician shall also be based on the credibility of the physician's opinion in light of its reasoning and documentation, other relevant evidence and the record as a whole. §718.104(d)(5).

I find that Dr. Pearl was Claimant's pulmonologist for many years and that Claimant treated with Dr. Pearl about every three to six months from 1993 through 1999. There is evidence Dr. Pearl saw Claimant in 2001 and 2004. Dr. Pearl is Board-Certified in Internal Medicine and was very familiar with Claimant's respiratory status. Therefore, I find based on the foregoing that, if found credible, Dr. Pearl's opinion would be entitled to controlling weight in this matter.

However, I find the opinion of Dr. Pearl is entitled to less weight, overall, because his opinion regarding the existence of pneumoconiosis is not well-documented and is equivocal. In his medical report of August 25, 2005, Dr. Pearl stated that he had treated Claimant since 1985 and at that time Claimant had chest x-ray abnormalities consistent with CWP. However, there is no mention of any kind in Dr. Pearl's office notes of a diagnosis of pneumoconiosis until April of 1999. He stated further that Claimant had radiographic and biopsy proof of pneumoconiosis but as I found earlier in this opinion the chest x-ray evidence was insufficient to establish the existence of pneumoconiosis. Moreover, contrary to Dr. Pearl's assertion, the biopsy evidence, as read by three pathologists, did not show evidence of pneumoconiosis.

Dr. Pearl issued a subsequent report after reviewing additional *unspecified* information. Based on this additional data, Dr. Pearl reversed himself and concluded Claimant did not have coal worker's pneumoconiosis. Because it is unknown what information Dr. Pearl reviewed in making this determination, I find his opinion is less persuasive.

Dr. Pearl noted the presence of emphysema and noted incorrectly that Claimant had been a non-smoker and attributed these changes, at least in part, to dust exposure. Dr. Pearl did not consider whether Claimant's previous smoking habit could have contributed to the formation of the emphysema noted on the biopsy and CT scan. Dr. Pearl then acknowledged that Claimant had been a smoker and had heavy exposure to silica dust but noted that a diagnosis of silicosis

was in question due to a lack of high volume of mineral material in the lungs. Dr. Pearl acknowledged the existence of an obstructive defect and stated that Claimant had no other etiology. He concluded that Claimant had parenchymal lung destruction "which may relate" to dust and diesel fumes in the mine. Again, I find Dr. Pearl's opinion unconvincing. He failed to consider the effects of cigarette smoking on Claimant's pulmonary condition and specifically his obstructive defect. Dr. Pearl instead concluded that Claimant's lung disease *may be related* to exposure to silica dust and fumes. This is far less than the reasonable degree of medical certainty standard that is required by the Act. In addition, Dr. Pearl's opinion is contrary to the biopsy evidence of record that showed the existence of a granulomatous disease process unrelated to pneumoconiosis. For the foregoing reasons, I accord the opinion of Dr. Pearl less weight on this issue.

Likewise, I accord less weight to the highly qualified opinion of Dr. Poitras on this issue. I find that his opinion is not well-reasoned and is not well-documented. Dr. Poitras concluded Claimant had a restrictive lung disease consistent with a fibrotic process such as pneumoconiosis found in coal workers. However, as I discussed earlier, the more credible x-ray evidence of record established that clinical pneumoconiosis was not present. I also find Dr. Poitras did not adequately explain his basis for concluding that Claimant's respiratory condition was consistent with a fibrotic process such as pneumoconiosis. Moreover, Dr. Poitras failed to explain how he was able to eliminate smoking as a possible cause of Claimant's respiratory condition. I also note that Dr. Poitras was unaware of the results of the 1999 lung biopsy when he rendered his opinion. Perhaps if he had a more complete medical picture of Claimant's actual condition, like Dr. Farney, his opinion would have been altered. For these reasons, I accord the opinion of Dr. Poitras less weight on this issue.

Conversely, I find the opinion of Dr. Farney is well-reasoned and is supported by the objective diagnostic testing in the record. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989)(en banc). His finding of no pneumoconiosis is consistent with Claimant's medical history, biopsy results, negative chest x-rays, objective diagnostic tests, occupational history, physical examination, and smoking history. Dr. Farney reviewed all of the relevant evidence of record and therefore had a clear clinical picture of Claimant's condition when rendering his opinion. Moreover, I am persuaded by Dr. Farney's thoughtful discussion, during his testimony and throughout his four medical reports, regarding his reasoning for finding no pneumoconiosis. For these reasons, I accord the opinion of Dr. Farney great weight.

I also note that there are four CT scan interpretations in evidence. The interpretations from September 29, 1994; February 28, 1999; and September 1, 2004 include coal worker's pneumoconiosis as part of a differential diagnosis. However, I find that the biopsy evidence, which is the gold-standard in identifying these types of nodules, is far more persuasive and convincing. A radiologist examining an image can not get the same detail that a pathologist does when reviewing an actual tissue sample microscopically. Accordingly, these interpretations will be accorded less weight.

Accordingly, based on the foregoing, I find the better reasoned medical opinion evidence fails to establish the existence of pneumoconiosis pursuant to §718.202(a)(4).

Accordingly, weighing all of the foregoing evidence together, I find Claimant has failed to established the existence of pneumoconiosis pursuant to §718.202(a).

Cause of Pneumoconiosis Pursuant to 718.203

Once it is determined that the miner suffers from pneumoconiosis, it must be determined whether the miner's pneumoconiosis arose, at least in part, out of coal mine employment. 20 C.F.R. 718.203(a). If a miner who is suffering from pneumoconiosis was employed for ten years or more in the coal mines, there shall be a rebuttable presumption that the pneumoconiosis arose out of such employment.

I find that Claimant, with twenty-six (26) years of coal mine employment, is entitled to the rebuttable presumption at §718.203. Because Claimant failed to establish the existence of pneumoconiosis, this element is moot.

Evidence of Total Disability

A miner shall be considered totally disabled if the miner has a pulmonary or respiratory impairment which, standing alone, prevents or prevented the miner from performing his usual coal mine work or comparable employment. §718.204(b)(1). Section 718.204 sets out the standards for determining total disability. This section provides that in the absence of contrary probative evidence, evidence that meets the quality standards of the subsection shall establish the miner's total disability.

Subsection 718.204(b)(2)(i) provides that total disability may be established by pulmonary function testing. There are eight pulmonary function studies submitted as part of Claimant's claim for benefits. As none of the studies were qualifying under the Act, I find that Claimant has failed to establish total disability due to §718.204(b)(2)(i).

Subsection 718.204(b)(2)(ii) provides that qualifying arterial blood gas testing may establish total disability. There are two arterial blood gas studies in the record. Only the exercise values in the May 25, 1999 test were qualifying under the Act. The subsequent, and most recent study, was not qualifying. Accordingly, I find that Claimant has failed to establish total disability pursuant to §718.204(b)(2)(ii).

There is no evidence that the Claimant suffers from cor pulmonale with right-sided congestive heart failure pursuant to §718.204(b)(2)(iii).

Subsection 718.204(b)(2)(iv) provides that total disability may be established if a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concluded that Claimant's respiratory or pulmonary impairment prevents him from engaging in his usual coal mine work or in comparable and gainful employment.

There are three (3) physicians who have rendered an opinion in this matter relative to this issue. Dr. Poitras opined Claimant had a mild to moderate impairment and that he was limited in

his physical activities. Dr. Farney opined Claimant's respiratory condition would not prevent him performing his last coal mine employment. Dr. Pearl opined Claimant had a pulmonary disability but that he did not have the information to quantitate the disability.

Because Dr. Pearl admittedly could not quantitate Claimant's disability, I accord his opinion less weight. Likewise, Dr. Poitras noted the presence of a mild to moderate pulmonary impairment but did not specifically indicate whether Claimant could perform the duties of his last coal mine job. Therefore, I find that his opinion is not well-reasoned. In addition, Dr. Poitras had limited information in making his determination and was not privy to the additional evidence reviewed by Dr. Farney in this matter. For these reasons, I accord his opinion less weight.

Conversely, I accord greater weight to the opinion of Dr. Farney who opined Claimant could perform the duties of his last coal mine job. Dr. Farney issued four medical reports in this matter and testified at length at the hearing. He reviewed all of the relevant evidence of record in making his determination. I find that his opinion is well-reasoned and well-documented and is accorded greater weight.

Accordingly, based on the foregoing, I find Claimant has failed to establish total disability pursuant to §718.204(b)(2)(iv).

In weighing all of the foregoing, I find Claimant has failed to establish the existence of a totally disabling respiratory impairment pursuant to §718.204(b).

Disability Causation

The final issue is whether Claimant has established disability causation at Section 718.204(c)(1).

Pursuant to §718.204(c)(1) a miner shall be considered totally disabled due to pneumoconiosis if pneumoconiosis…is a substantially contributing cause of the miner's totally disabling respiratory impairment. Pneumoconiosis is a "substantially contributing cause" of the miner's disability if it:

(i) Has a material adverse effect on the miner's respiratory or pulmonary condition; or
(ii) Materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment.

Because Claimant failed to establish the existence of pneumoconiosis and the presence of a totally disabling pulmonary impairment, this element is moot.

Conclusion

Because Claimant has failed to establish all elements of entitlement, I must conclude that he has failed to establish entitlement to benefits under the Act.

Order

The claim of CLYDE GRAMES for benefits under the Act is hereby **DENIED**.

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Russell D. Pulver
Administrative Law Judge

Attorney Fees

The award of an attorney's fee under the Act is permitted only in cases in which Claimant is found to be entitled to benefits. Since benefits are not awarded in this case, the Act prohibits the charging of any fee for services rendered to him in pursuit of this claim.

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. §725.481, any party dissatisfied with this Order may appeal it to the Benefits Review Board within 30 days from the date of this decision, by filing a Notice of Appeals with the Benefits Review Board, P.O. Box 37601, Washington, D.C. 20013-7601. A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits. His address is Room N-2117, Frances Perkins Building, 200 Constitution Avenue, N.W., Washington, D.C. 20210.